Dermatology Coding Alert

Don't Underestimate Justifying Medical Necessity for Benign Lesion Excisions

Provide more than one reason code, or you may face denials

If your dermatologist performs procedures on benign lesions, and you\'re facing denials for these claims, you should make sure you report Category III codes with your Category II codes to justify medical necessity.

The first step in coding benign lesion removal is to choose the most appropriate code from the various categories of payable CPT codes.

To help you make sure you haven\'t underreported the medical necessity of these procedures, we\'ve put together a short list, with the assistance of **Jeffrey Weinberg, MD,** director of the Clinical Research Center, Department of Dermatology at St. Luke\'s-Roosevelt Hospital Center in New York City.

The table to the right provides an overview of the payable CPT codes for benign lesion removal.

Example: A patient presents to your practice with three different skin tags on her neck. Your dermatologist removes these skin tags. You should report 11200 for this procedure.

Explanation: Because 11200 is a payable procedure, payers should reimburse you for it. The tricky part is that you have to report a corresponding diagnosis code that may or may not justify medical necessity, if you\'re not careful.

Category II Codes Can\'t Stand Alone

When you report any of the procedure codes, you need to justify the medical necessity of the procedure with a corresponding ICD-9 code. You do so by providing a corresponding Category I, II or III ICD-9 code, says **Linda Martien, CPC, CPC-H,** National Healthcare Review in Woodland Hills, Calif.

Category I codes identify what kind of lesion your dermatologist treated and also define the medical necessity of the services your dermatologist provided, Martien says. But Category II codes describe diagnoses that carriers will reimburse your **dermatology practice** for if the patient presents with a complication, as identified in the Category III codes, she says.

Red flag: If you report a Category II code, you must also report a Category III to describe the complication.

Example: A patient comes to your practice with a cyst on her eyelid. She reports that the cyst is causing her some discomfort and she\'s having difficulty seeing out of that eye. The dermatologist removes the cyst, and you report code 11440 for the procedure. You then report Category II code 706.2 (Sebaceous cyst) as the diagnosis code.

Watch out: If you don\'t report a Category III code to indicate that there was a complication with this cyst, Medicare will deny your claim as a cosmetic procedure.

Solution: Therefore, you should also report Category III code 369.8 (Unqualified visual loss, one eye) to tell the carrier that the cyst impaired the patient\'s vision, Martien says.

Editor\'s note: See \"Refer to This Chart for Corresponding Medical-Necessity Codes of Benign Lesions\" in this issue for a list of the Category I, II and III codes.